Stormont Vail Health

1022

Photography/Image Authorization Form

I give my consent to Stormont Vail Health to make and use images of the person listed below as described in this form.

_____ _____

Name Date of Birth

Images may be used for the following purposes:

____ Internal Use (including education or quality/performance improvement)

____ External Use, Specifically:

____ Media Interview* ____ Advertisement or Printed Material*

____ Display* ____ Medical Publications or Website*

____ Medical/Other Education ____ Televised/Commercial Programming*

____ Research ____ Social Media*

____ Other* _____

____ All of the above*

*Prior to the event, Marketing and Communications must approve and coordinate all activities

- I understand that this Authorization applies to images in any format, including photographs, video recordings, audio recordings, digital and electronic recordings, films, or other images of any type that may be taken of me for purposes other than medical care.
- I understand that such photographs or images may be used for internal and external purposes. Internal use may include performance improvement efforts or education. External use may include commercial filming, televised programming, or marketing media intended either for the public or for the education of non-Stormont Vail Health employees.
- I understand that every effort will be made to obtain my authorization prior to filming/recording/photographing. If authorization cannot be obtained prior to the filming/recording/photographing, then such images will not be used unless my consent is obtained and documented.
- I understand that I may request that recording/filming be stopped at any time.
- I understand that I may rescind my consent at any time by notifying the Stormont Vail Health Marketing and Communications Department at (785) 354-6120. If I rescind my consent, then the images in Stormont Vail Health's possession or control will be destroyed or my image will be removed from the product before further use. However, I understand that rescinding my consent will have no effect on prior use of the images. I further understand that I must directly notify the entity named below in order to rescind my consent if the images are not in Stormont Vail Health's possession.

- I understand that images contained in my medical record and made for purposes of medical care will not, under any circumstance, be removed from my medical record.
- I understand that such images are the property of Stormont Vail Health or the entity that created such images (Name of Entity: _____), and that I will not be notified prior to use or publication of the images. I understand that I will not have any opportunity to view or approve the image prior to its use.
- I understand that there will be no remuneration paid to me or anyone related to me for the use of these images.

_____

Signature of Subject/Patient/Legal Guardian (if under 18)

_____

Address/City/State/Zip

_____ _____

Witness Date

_____

Address/City/State/Zip

REVOCATION

I hereby rescind the consent documented above.

_____ _____

Name Date